A Time To Die: Moral Considerations in Dutch Euthanasia Policy

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ABSTRACT: A law passed in the Netherlands allows patients to request euthanasia or assisted suicide if three requirements are met. However, this law has sparked recent controversy because it allowed a man who experienced severe alcoholism to be euthanized. This essay explores the moral-legal issues that arise from this situation and how those concerns should be weighed for effective policy. I argue that it is ethically permissible and therefore should be legal for patients to have access to euthanasia or assisted suicide if the patients meet the requirements of having requests that are voluntary, well-considered and can demonstrate that there is no prospect of improvement.

Introduction

A law passed in the Netherlands allows patients to request euthanasia or assisted suicide if three requirements are met. I will now expound the guidelines of the euthanasia policy. The first directive is that the request must be (1) voluntarily made by the patient. The application must also be (2) well-considered, durable, and consistent and finally, (3) the patient must be experiencing unbearable suffering, and there must be no prospect of improvement. Mark Langedijk, a man with an alcohol addiction, chose to be euthanized after several failed attempts at rehabilitation. Now that news of Mr. Langedijk's euthanization has spread, many people are outraged. *The Washington Times* reported politicians are pointing to the death as a manifestation of dangers surrounding the legalization of physician-assisted suicide (Richardson). Moreover, this instance of assisted suicide adds to a long-standing list of worries about the euthanasia policy. The problems with the policy raise the following question for policymakers, doctors, and philosophers: Is it ethically permissible for patients who are suffering from non-lethal conditions like alcoholism to have access to euthanasia?

In this essay, I argue that it is ethically permissible for patients to have access to euthanasia or assisted suicide if the patients meet the requirements of having requests that are voluntary, well-considered and can demonstrate that there is no prospect of improvement. Having this policy is ethical because it allows the minimization of harms to the patient. This reduction in damages includes the mitigation of slippery slope worries and safeguards against the actualization of those concerns about the policy being a dangerous precedent for society at large.

In section 1, I will expound on the utilitarian framework through which this policy is argued. In my explanation of the moral framework, I identify and justify patient suffering and harm as most important ethical consideration in this case. In Section 2, I will clarify the terminology of the policy I am promoting, by defining "voluntary," "well-considered," and "no prospect of improvement." Subsequently, I will address objections to my view on this policy. The most forceful complaint that I will discuss is that allowing patients access to euthanization sets a threatening precedent for society at large. Despite the worries about the euthanasia law, the requirements of the policy inoculate the chance of these worries coming to fruition.

Framework and Position

In response to the central ethical question I have raised, I argue that it is ethically permissible for patients who are suffering from non-lethal conditions like alcoholism to have access to euthanasia as a remedy because it provides an efficient way to mitigate the patient's suffering. Although I have herein implied that harm and suffering is the primary ethical concern, there are at least three prominent ethical principles to consider. The first factor is that of patient autonomy, the second is the doctor's right to disdain euthanization because of personal moral conflict, and the third is the suffering of the patient's family. I will now explain why I have not chosen to prioritize these principles throughout my argument.

First, patient autonomy is not the chief ethical concern because if it were, we would be morally subject to whatever exercise of autonomy the patient desired. Hallvard Lillehammer, a professor of philosophy at Birkbeck College in London that has provided essential research on the euthanasia policy, expressed this sentiment in his article "Voluntary Euthanasia and The Logical Slippery Slope Argument." The report was responding to an argument made by John Keown, another scholar that frequents the euthanasia debate, who considered autonomy to be the most important ethical principle for this policy (Lillehammer, 2002).

Second, the doctor's right to disdain performance of euthanization because of personal moral conflict is not jeopardized and therefore, is not deserving of our ethical inquiry. Physicians cannot be forced or required to perform euthanasia on their patients because it is foreseeable that some will have moral objections to the practice. The physicians are obligated, however, to help their patients contact another physician who does not have moral objections (Cohen 2003, pp. 240).

The primary ethical consideration cannot be the suffering of the patient's family. If the plight of the patient's family is principal, then any desires the family has about the patient become the final word in medical, legal, and ethical affairs. Positing the family's suffering as primary devalues any ethical sensitivity we have to the patient's autonomy. I certainly do not suggest that patient autonomy, the doctor's right, or the family's suffering are not worthy of rumination— I merely qualify these concerns as subsidiary. Since the patient's harm and suffering is the most critical ethical concern, we need a policy that allows us to minimize that anguish in the patient's experience.

The Policy for Assisted Suicide/ Euthanasia

Before we can fully understand that Langedijk's euthanization and situations like it are ethically permissible under the policy for assisted suicide in the Netherlands, we must understand the law that allows euthanasia. I mentioned before that the law has three primary requirements for patients' euthanization. Those elements were that the request is voluntary, well considered and that the patient is experiencing unbearable suffering with no prospect of improvement. Each of these stipulations is clarified in this section.

When it is said that the requests must be voluntary, I mean that there cannot be coercion to lead the patient to this decision. Coercion includes but is not limited to the pressure of the family to end the financial burden caused by the patient's addiction, persuasion by health insurance providers to submit a request, or suggestion by a physician. It is a foreseeable danger that if this provision in the policy were not included, health insurance companies might give their clients the option of euthanization over continued treatment. Raphael Cohen-Almagor, a renowned scholar and human rights activist, provides an example that adequately addresses the term voluntarily. In his research, he recorded that "sometimes families find the suffering of their loved one

unbearable and that there has been incidental anecdotal evidence of family pressure being brought to bear in the termination of a patient's life" (Cohen 2003, pp. 250). Instances like the one Cohen reports are examples of what constitutes an involuntary request.

The policy also requires that the request be well considered, durable and consistent; this requirement is an effective procedural one that means both that patients are persistent in their demands and that the physician has consulted with another doctor as well as to consider the request (Cohen 2003, pp. 239). For an application to satisfy this prerequisite, a patient must have exhausted a considerable level of treatment or rehabilitation services. The patient must also be made aware of all treatment options available to them. To be clear, instances in which doctors administer euthanasia or present the possibility rather than giving the patient treatment fail under this test. The patient's doctor must be convinced that their patient has exhausted treatment options or that the avenues for recovery that remain are unfeasible for the patient. The physician must then obtain a second opinion from another doctor (Hendin, 200 pp. 226). If both doctors are convinced, the patient can submit a request that will be reviewed by the Support and Consultation in Euthanasia (SCEN) doctors. This process ensures that the patient cannot act on an impulse when deciding to end their life. Everyone involved should give the possibility of euthanasia or assisted-suicide satisfactory consideration in comparison with other alternatives for mitigating.

When I say that the policy must require that there is no prospect of improvement, I mean that in addition to utilizing all available treatments, there must be evidence that the likelihood of recuperation is minimal. There must also be unbearable suffering that cannot be relieved; the suffering component is one of the necessary requirements of the policy. Whether or not there is any prospect of improvement will be determined by the medical professionals working with the patient. Herbert Hendin, a professor at New York Medical College, provides us an example of someone that did not meet the requirement: a woman who was physically healthy and fifty years old lost her son to cancer, and, as a result, she suffered from depression. Despite attempts by a psychiatrist to help her work through the problem, the woman refused psychiatric help with confronting the harsh reality of her son's death. According to Hendin, the woman did spend two months seeing a psychiatrist, but this time was spent trying to convince the psychiatrist to assist her in dying (Hendin, 2002 pp. 235).

On its face, the narrative suggests that the woman who suffered mental anguish experienced unbearable suffering. The narrative is believed, extraordinarily, to the extent that the courts ruled that the doctor behaved correctly regarding the patient once the patient had been euthanized. Hendin states that the psychiatrist told him "…that his patient suffered from incurable grief. Her refusal of treatment was considered by him to make her suffering unrelievable…. if he did not help her she would kill herself without him" (Hendin, 2002 pp. 236). The request of this woman did not meet the requirement of intolerable suffering with no prospect of improvement, nor did it meet the condition of being well-considered; she had not exhausted treatment options. If the patient had shown serious effort to improve her condition by going through treatment, she would have met the standard for adequate consideration. Furthermore, lack of improvement after therapy would be enough to meet the standard of unbearable suffering.

The Case for Langedijk

Mark Langedijk suffered from severe alcoholism for most of his life. At the age of forty-one, he had already tried twenty-one times to recover from his problem of addiction through

rehabilitation and had been hospitalized numerous times during the process (Richardson, 2016). Unfortunately, all his attempts were unsuccessful. At first glance of this case, if Langedijk had started drinking at the legal drinking age, which is 16 in the Netherlands, these attempts would have amounted to 1 effort per year by the age of 41. However, the facts are much graver: Langedijk reached out for help 21 times in 8 years (Doughty, 2016). When it was clear to him that his condition would not improve, Mark decided that he couldn't live as an alcoholic anymore. Having exhausted all feasible options for treatment and rehabilitation, Langedijk turned to assisted euthanasia (Richardson, 2016).

Although Langedijk had no "terminal" illness (by terminal illness I suggest something such as cancer in its terminal stages), he meets all criterion for euthanization under the Dutch policy. The rules prove to be instrumental in minimizing the harm and suffering Langedijk can experience. It is true that rules constitute legality, and that whatever is legal is not always ethical; but, the law allowing euthanasia transcends legality into ethicality because of its minimization of harm and suffering in an efficacious manner. Under the first requirement that the decision must be voluntary, the harm and suffering that Langedijk can experience are reduced by respecting his patient autonomy. Recall, that Langedijk's sovereignty is not the chief ethical concern, but it is fundamental in moving forward with this policy. Still, if the patient's autonomy is not respected, we inevitably risk acting against the patient's will, meaning that if there were no desire to die, euthanization would be murder. Few people would rationally suppose that death by murder does not constitute harm to the patient, because when a person imagines this reality for themselves, they understand the violation of their will to be harm to their person. When a person's will is violated, anguish will ensue, and this situation necessitates heinous suffering. The term suffering as used here refers to physical pain or mental anguish.

The provision in this law that declares that decisions must be well-considered also reduces harm and suffering. The standard of well-considered, durable, and consistent has been set up, and this guideline also serves to minimize the harm and suffering of Langedijk. Harm and suffering are reduced by ensuring that, at least when the standard is followed, the patient cannot have his request granted to him if it goes against his well-being and flourishing. Built into this requirement is that the patient must be made aware of all available treatment options. If the patient determines that he no longer wishes to be treated, doctors must stop treatment. Therefore, the doctors have no right to euthanize in this event because it contradicts the third guideline, and the most viable way to minimize Langedijk's harm and suffering is to follow these instructions collectively (Cohen, 2003 pp. 240). If each instruction is not observed in conjunction with the others, the effects of the instructions are negligible.

For Mr. Langedijk's request to be considered, his doctor had to be thoroughly convinced that all other methods of treatment had been exhausted, or that those plans were recognizably unfeasible, and that unbearable suffering is involved. Unbearable suffering means that the condition of the patient cannot or is extremely unlikely to be improved. Following this guideline protects patients from the harmful results of making a hasty end of life decision. I return to the example provided to us by Hendin. Although the psychiatrist who saw her, Boudewijn Chabot claimed that the patient "suffered from incurable grief," the grief was not what he declared it to be (Hendin, 2002 pp. 236). Hendin points out that Chabot paid no attention to the fact that if given more time to deal with her son's death, the woman likely would have changed her mind. The request did not meet the last requirements because a well-considered request must have examined and utilized its resources (Cohen 2001, pp. 236), and the condition of the patient might have improved if she had given it the chance.

Objections

The first counterclaim that I will consider, and the most forceful one, is the slippery slope worry that allowing patients suffering from nonlethal conditions to have access to euthanasia as a remedy for extreme suffering is a dangerous precedent; eventually, the option will be available to an increasing number of people. Since 1990, there has been an increase in the number of people requesting to be euthanized (Cohen, 2001 pp. 38). Currently, people below the age of 12 years, as well as psychiatric patients, are seeking their life's termination in growing numbers. Included with these requests are some based on "social isolation and loneliness" (Richardson, 2016).

The people claiming social isolation, loneliness, psychiatric patients, and people below the age of 12 will not fit the bill in this consideration as a typical rule on these bases alone. Here, I reiterate that the requirements must be met that the requests are voluntary, well-considered and that there is intolerable suffering with no prospect of improvement. If each of the guidelines is followed, many of the people submitting the requests will not have their requests granted because they fail to satisfy the basal demands of the policy. Consequently, physician-assisted euthanasia will not become a routine act. Secondly on that point is this: just because people are submitting applications in higher numbers doesn't mean that these people will have their applications approved. Ultimately, objecting to this policy by arguing it as a dangerous precedent is misconstruing the option to help terminate a patient's life as a first resort for people suffering from conditions of alcoholism or similar conditions like Mr. Langedijk. However, the decision for euthanization was not an easy one for the Langedijks. The amount of effort Langedijk put in to provide a well-considered and persistent request demonstrates that it was not Mr. Langedijk acting off a whim, it was legitimately the best available remedy for suffering. Thus, the guidelines hold full ability to safeguard against slippery slope worries such as this.

Furthermore, it is argued that doctors must not harm or, at the very least, reduce harm and suffering as much as is within their power to reduce it. By helping the patient die, the doctor increases the amount of harm and suffering for the patient, as well as the family because they will be distraught from losing a loved one: this argument is the argument from beneficence. While this argument voices a practical concern, it does not sufficiently stand. Allowing doctors to euthanize patients when their requests meet all the criteria does provide a way to minimize the harm and suffering of the patient. If patients who are suffering unbearably with conditions like alcoholism are not allowed access to euthanasia or assisted suicide, there is a higher chance that someone will experience unbearable suffering. Mr. Marcel Langedijk, the brother of the man this case was written about, pointed out in an interview that this method of dying was unquestionably the most peaceful. The alternative of letting Mark deal with this problem and not euthanizing him after a request that met each requirement that has been set could lead to a crueler kind of death. Marcel mentions that his brother could have shot himself or stood in front of a train waiting to be hit; these possibilities brought a great deal of uncertainty for the family. At least with the euthanasia arrangement, that was initiated by Mark himself, Mark and his family were sure of the day and time of death and they were more apt to deal with what was happening (BBC News, 2016).

If Mark had killed himself in one of the ways his brother mentioned, more people would have been negatively affected— the people who would see him kill himself or after the act would be done. Allowing doctors to mitigate the transition from life to death in this way is the much

more humane option since it provides for the reduction of harm and suffering to the patient primarily, but also to the family of the patient.

Conclusion

The euthanasia policy declares that all requests must be voluntary and free, well-considered and persistent, and entail unbearable suffering with no likely prospect of improvement. If each of these guidelines is followed by the specificity required in the policy, we can adequately minimize both harm and suffering for each patient that finds themselves in this position. Reducing harm and suffering indeed involves respecting the patient's autonomy, considering the doctor's right to abstain from performing euthanasia due to its moral objectionability to him or herself, and considering the suffering of the family. These concerns are crucial as secondary ethical concerns to minimizing the patient's harm and suffering. Although there is considerable controversy surrounding the euthanasia policy, the policy and its guidelines provide a way for us to minimize harm and suffering patients who are suffering from nonterminal illnesses like alcoholism. In the end, the minimization of harm and suffering makes allowing patients the access to euthanasia or medically-assisted suicide ethically permissible.

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